



**To Use Massachusetts Paid Family And Medical Leave To:
Care for a family member with a serious health condition**

Complete Form MA PFML -1

- Complete MA PFML-1, Part A
- Provide MA PFML-1 to employer
- Employer completes MA PFML-1, Part B and returns to you within 3 days

Complete Form MA PFML -3

- Care recipient completes MA PFML-3 and provides to health care provider
- Care recipient's health care provider keeps MA PFML-3

Complete Form MA PFML -4

- Complete "Employee" information at the top of MA PFML-4
- Provide MA PFML-4 to care recipient's health care provider
- Care recipient's health care provider completes MA PFML-4 and returns to you

Send forms and documents

- Send completed forms and supporting documentation to The Standard
- The Standard accepts or denies claim within 14 days

Please keep a copy of all pages for your records.

- To request Massachusetts Paid Family And Medical Leave (MA PFML), the employee requesting MA PFML must complete Part A of the *Request For Massachusetts Paid Family And Medical Leave* (Form MA PFML-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Massachusetts Paid Family And Medical Leave* (Form MA PFML-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request For Massachusetts Paid Family And Medical Leave* (Form MA PFML-1) with the required additional form to The Standard. The employee should retain a copy of each submitted form for their records.

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting MA PFML must complete all required information.

Massachusetts Paid Family And Medical Leave (MA PFML) Request (to be completed by the employee)

Question 10: Family member means the spouse, domestic partner, child, parent or parent of a spouse or domestic partner of the employee; a person who stood in *loco parentis* to the employee when the employee was a minor child; or a grandchild, grandparent or sibling of the employee.

Child means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands in *loco parentis*.

Grandchild means a child of the employee's child.

Grandparent means a parent of the employee's parent.

Parent means the biological, adoptive, step-brother or step-sister of the employee.

Spouse means a husband or wife or domestic partner of an employee.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested MA PFML. These dates should be the actual dates that the MA PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates MA PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If dates are estimated, The Standard may require you to submit a request for payment after the MA PFML day is taken. Payment for approved claims will be due as soon as possible but in no event more than 14 days from the date of the completed request.

Question 12: Date employer was notified. If the employee is submitting the MA PFML request to their employer with less than 30 days' advance notice from the start date of the MA PFML, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 14: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 18: List all other income you will be receiving while on MA PFML. Include the type/name of income and how much. Example PTO from employer for \$500.00 a week.

If you are pre-submitting form: Indicate if the employee is pre-submitting their MA PFML request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by The Standard, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The Standard will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Once all information is supplied, The Standard has 14 days to pay or deny the claim.**

If The Standard does not permit pre-submitting, The Standard must return the Request for Massachusetts Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting MA PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 8. You can call the state or check through the employer portal for this information.

“Wage” or “wages” means: For the purpose of payment of benefits, the remuneration paid by one or more employers to an employee for employment during the employee’s qualifying period.

Average Weekly Wage will be based on the weekly Wages in effect with the Employer on the day immediately preceding the date Family or Medical Leave under the Group Policy begins. For former Employees, the Average Weekly Wage will be based on Wages that were in effect on the last day the former Employee was in the employment of the Employer. For Covered Individuals who are paid hourly, the Average Weekly Wage is based on the hourly pay rate multiplied by the number of hours regularly scheduled to work for the Employer per week, but not more than 40 hours. If the Covered Individual does not have regular work hours, the Average Weekly Wage is based on the average number of hours worked per week for the Employer during the preceding 52 calendar weeks (or during the period of employment with the Employer if less than 52 weeks), but not more than 40 hours. If a Covered Individual has multiple Employers, the Average Weekly Wage will be calculated for each employer or Covered Business Entity separately.

Employer signs and dates, and then returns to the employee requesting MA PFML within three business days.

Be sure to complete the appropriate additional MA PFML form(s) based on the type of MA PFML leave being requested.

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)	2. Other last names, if any, under which employee has worked			
3. Employee's mailing address Street	City	State	Zip Code	Country (if not USA)
4. Employee's Social Security Number or TIN	5. Employee's date of birth (MM/DD/YYYY)	6. Employee's primary telephone number ()		
7. Employee's preferred email address while on MA PFML (if available)		8. Employee's gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other		
9. Reason for MA PFML request: <input type="checkbox"/> Bond with child <input type="checkbox"/> Care for family member <input type="checkbox"/> Military qualifying event <input type="checkbox"/> Own serious health condition <input type="checkbox"/> Care of a family member who is a service member				
10. The family member is employee's: <input type="checkbox"/> Child <input type="checkbox"/> Spouse or registered domestic partner <input type="checkbox"/> Sibling <input type="checkbox"/> Parents and legal guardians (or spouse's parent) <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild				
11. Will MA PFML be for a continuous period of time and/or periodic? <input type="checkbox"/> Continuous _____ / _____ / _____ MA PFML start date (MM/DD/YYYY) _____ / _____ / _____ MA PFML end date (MM/DD/YYYY) <input type="checkbox"/> Dates are estimated				
Identify dates periodic MA PFML will be taken: <input type="checkbox"/> Periodic _____ <input type="checkbox"/> Dates are estimated				
If providing less than 30 days advanced notice to the employer, please explain: _____				

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain: _____

Employment Information (to be completed by the employee)

13. Business name	14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)		
15. Employee's work location Street address	City	State	Zip code	Country (if not U.S.A.)
16. Employer's telephone number for contact regarding this request. ()	17. Is employee currently receiving Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
18. List pay you will be receiving while on MA PFML, source of pay and amount.				
19. Have you taken any leave in the last 52 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	20. If yes list dates and type of leave.			

Disclosure statement: Information regarding MA PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
I am hereby making a request for paid family and medical leave benefits under the Massachusetts State Paid Family And Medical Leave Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature	Date signed (MM/DD/YYYY)
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I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address			
Mailing address			
City	State	Zip code	Country (if not U.S.A.)
2. Employer's FEIN			
3. Employer's EIN		4. Employer's contact name for questions related to MA PFML	
5. Employer's contact telephone number ()		6. Employer's contact email address	
7. Employee's date of hire (MM/DD/YYYY)		7a. Employee's last day of work (MM/DD/YYYY)	
8. Employee's Average Weekly Wage			
9. Employee's Typical Work Week Hours			
10a. Check Days Normally Worked <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday			
10b. Is employee hourly or salaried? <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried			
11. List the last date the employee will receive pay, for example the last date through which sick leave benefits, if any, will be paid.			
12a. What type of paid benefits will the employee receive while on MA PFML? Include the last date through which any compensation will be paid.			
12b. If, while on fully-insured MA PFML, the employee will receive wages in the form of sick leave, PTO, vacation or an extended illness leave bank that is at least equal to the benefit under the Group Policy, will the employer be requesting reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Is the employee taking federal Family Medical Leave Act (FMLA)? <input type="checkbox"/> Yes <input type="checkbox"/> No		14. MA PFML policy number	
MA PFML insurance carrier's name and mailing address Standard Insurance Company PO Box 3877 Portland, OR 97208 866-751-5174 Fax			
Declaration and signature <input type="checkbox"/> I affirm the employee meets the eligibility for Massachusetts Paid Family And Medical Leave. I am the person authorized to sign as the employer of the employee requesting MA PFML. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.			
Employer's authorized signature		Date signed (MM/DD/YYYY)	
Title			

**Massachusetts Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form MA PFML-3)**

Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

- If an employee is requesting Massachusetts Paid Family And Medical Leave (MA PFML) to care for a family member with a serious health condition, the family member or an authorized representative must complete a *Release Of Personal Health Information For Family Member* (Form MA PFML-3) and submit it to their health care provider, along with a copy of the *Certification For Care Of Family Member* (Form MA PFML-4).
- The *Release Of Personal Health Information For Family Member* (Form MA PFML-3) enables the health care provider to complete *Certification For Care Of Family Member* (Form MA PFML-4) and release it to the employee seeking MA PFML benefits.
- Before completing and signing, the family member must read the *Release Of Personal Health Information For Family Member* (Form MA PFML-3) in its entirety.
- The employee requesting MA PFML submits both the *Request For Massachusetts Paid Family And Medical Leave* (Form MA PFML-1) and the *Certification For Care Of Family Member* (Form MA PFML-4) to their employer's MA PFML insurance carrier, for MA PFML benefit determination.

NOTE: This form will be retained by the health care provider. The employee should make a copy for their records before giving it to the health care provider.

Family member or authorized representative signs and dates.

This form is given to the family member's health care provider along with the *Certification For Care Of Family Member* (Form MA PFML-4).

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's health care provider with Form MA PFML-4)

Employee enters their name, and family member's name and date of birth at the top of each page.

The MA PFML insurance carrier name requested at the top of the form is the same as the MA PFML insurance carrier identified in *Request For Massachusetts Paid Family And Medical Leave* (Form MA PFML-1) Part B line 13.

Family member or authorized representative must complete all applicable requested information.

If a family member is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the family member. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

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Release Of Personal Health Information
For Family Member
(Form MA PFML-3)**

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TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Family member's legal name	Family member's date of birth (MM/DD/YYYY)
Relationship of family member to employee	If family member is employee's son or daughter, date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's health care provider with Form MA PFML-4)

I, _____, Family member's legal name, authorize my health care provider listed on this form to release my personal health information to _____ and Standard Insurance Company. Employee's legal name

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Massachusetts Paid Family And Medical Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

HIV/AIDS related information Mental health information Alcohol/drug treatment Psychotherapy notes

Health Care Provider Information (to be completed by the family member or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for MA PFML benefits.

1. Health care provider's name

2. Health care provider's mailing address

City	State	Zip Code	Country (if not U.S.A.)
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3. Health care provider's telephone number (provide area or country code)
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For Family Member
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Standard Insurance Company

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PO Box 3877 Portland OR 97208

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first legal name, middle initial, last name)	
Family member's legal name (first name, middle initial, last name)	Family member's date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's health care provider with Form MA PFML-4)

Family member Information (to be completed by the family member or authorized representative)			
4. Family member's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
5. Family member's Social Security Number		6. Family member's telephone number (provide area or country code) ()	

READ AND SIGN BELOW

I have a serious health condition and thereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition* (Form MA PFML-4) to the employee identified on Form MA PFML-4, I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting MA PFML benefits as a result of my current condition.

Family member's signature	Date signed (MM/DD/YYYY)
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Authorized representative

I, _____, represent the family member in this matter as authorized by:

Print legal name

Parental right Power of attorney (attach copy) Court order (attach copy) Health care proxy (attach copy)

Authorized representative's signature	Date signed (MM/DD/YYYY)
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The employee should retain a copy for their own records.

To Be Completed by Employee

INSTRUCTION to the EMPLOYEE: The employee requesting Massachusetts Paid Family And Medical Leave (MA PFML) to care for family member with a serious health condition must submit the *Certification For Care Of Family Member (Form MA PFML-4)* with *Request For Paid Family and Medical Leave (Form MA PFML-1)*. Fill out the employee information of this form and give to the health care provider along with *Release Of Personal Health Information For Family Member (Form MA PFML-3)*. When you receive the completed *Certification For Care Of Family Member (Form MA PFML-4)* from the healthcare provider, send the completed forms and supporting documentation to The Standard.

Employee's Name				
Employee's Address	City	State	ZIP	Phone No.
Family member's Name	Relationship of family member to employee	If family member is employee's son or daughter, date of birth		
Family member's Address	City	State	ZIP	Phone No.

To Be Completed By Health Care Provider**INSTRUCTIONS for HEALTH CARE PROVIDERS**

This form is used to certify a serious health condition in order to qualify for MA PFML. Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the family member.

SERIOUS HEALTH CONDITION

A "serious health condition" is an illness, injury, impairment or physical or mental condition that involves: (a) inpatient care in a hospital, hospice or residential medical facility; or (b) continuing treatment by a health care provider.

Inpatient care: An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care; or

Continuing treatment by a healthcare provider: A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

- **Incapacity:** A period of incapacity of more than three consecutive days and subsequent treatment or period of incapacity relating to the same condition.
- **Pregnancy:** Any period of incapacity due to pregnancy, or for prenatal care;
- **Chronic conditions:** Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:
 - Continues over an extended period of time, including recurring episodes of a single underlying condition;
 - Requires periodic visits to a health care provider; and
 - May cause episodic rather than a continuing period of incapacity, including asthma, diabetes, and epilepsy
- **Permanent/Long-term:** A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider, including Alzheimer's, a severe stroke, or the terminal stages of a disease; or
- **Multiple treatments:** Any period of absence to receive multiple treatments, including any period of recovery from the treatments.
- Substance abuse may be a serious health condition if the treatment meets other requirements in this definition.

HEALTHCARE PROVIDERS

Healthcare provider is an individual licensed by the State in which the individual practices to practice medicine, surgery, dentistry, chiropractic, podiatry, midwifery or osteopathy, and including the following:

- Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in by a State and performing within the scope of their practice as defined under that State's law;
- Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are performing within the scope of their practice as defined under State law;
- Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts.
- A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the person's practice as defined under such law.

Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except such information required to make a determination that the person is eligible to take the leave, or as otherwise specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history (excluding the medical history of the family member whose condition necessitates this leave), the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART A: MEDICAL FACTS

1. Diagnosis _____ Primary ICD Code (optional) _____
 Approximate date condition commenced: _____ Probable duration of condition: _____
 Was the family member admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes No
 If so, dates of admission: _____

 Date(s) you treated the family member for condition: _____

 Will the family member need to have treatment visits at least twice per year due to the condition? Yes No
 Was the family member referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes No
 If so, state the nature of such treatments and expected duration of treatment: _____

2. Is the medical condition pregnancy? Yes No If so, expected/actual delivery date: _____
3. Complications with the pregnancy or delivery? Yes No Please explain: _____

4. Describe other relevant medical facts, if any, related to the condition for which the family member needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

5. If a service member, is the condition connected to the service member's military service? _____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your family member's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

6. Will the family member be incapacitated for a single continuous period of time, including any time for treatment and recovery? Yes No
 Estimate the beginning and ending dates for the period of incapacity: _____
 During this time, will the family member need care? Yes No
 Explain the care needed by the family member and why such care is medically necessary: _____

 If providing less than 30 days advanced notice to the employer, please explain: _____

7. Will the family member require follow-up treatments, including any time for recovery? Yes No
 Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

 Explain the care needed by the family member, and why such care is medically necessary: _____

8. Will the family member require care on an intermittent or reduced schedule basis, including any time for recovery? Yes No

Estimate the hours the family member needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the family member, and why such care is medically necessary: _____

9. Will the condition cause episodic flare-ups periodically preventing the family member from participating in normal daily activities?

Yes No

Based upon the family member's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the family member may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Does the family member need care during these flare-ups? Yes No

Explain the care needed by the family member, and why such care is medically necessary _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name		Date	
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice		License No.	

I declare under penalty of perjury that the information provided in this form is true and correct, that the family member's condition meets the definition of "serious health condition", an illness, injury, impairment or physical or mental condition that involves:
 (a) inpatient care in a hospital, hospice or residential medical facility; or (b) continuing treatment by a health care provider.
 and that I am a healthcare provider authorized to certify their condition [RCW 50A.05.010 ; WAC 192-500-090].

Signature of Health Care Provider	Date
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